STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. BUILDING _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER CREEK NURSING AND REHABILITATION CENTER	524 WARDELL ROAD TINTON FALLS, NJ 07753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is not in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal.	E 015		10/3/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/20/2023

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E 015	Continued From page 1 *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility documents, it was determined that the facility failed to have all of the menu items in stock in accordance with facility policy and emergency menu. The deficient practice was evidenced by the following: On 08/22/23 at 9:35 AM, during a kitchen tour with the Food Service Director (FSD), the surveyor observed the following items in the emergency food area apple sauce and mashed potatoes that were expired on 2/2022. There was no other food that was available in the area. The	E 015	1. The expired food in the emergency food area was discarded. The emergency food storage area was restocked with the items listed on the three-day disaster menu. 2. All residents have the potential to be affected by this cited practice. 3. The Food Service Director was educated by the Administrator on the requirement to ensure that a 3-day emergency food items is maintained at all times and kept separate from the regular food storage. 4. The Administrator/designee will check the emergency food storage area monthly	

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E 015	Continued From page 2 FSD stated that he was in the process of ordering the emergency food supply. During an interview on 8/23/23 at 8:55 AM, the FSD stated that he had ordered the food on the list and would have the food today. He said that he had been short-staffed, had been cleaning out the expired food for the emergency food storage area, and was reordering the food. During an interview on 8/29/23 at 11:40 AM, the FSD stated that the emergency supply of food needed to be ordered because the food had all expired at once. He stated that the three-day emergency food was not kept together in one area. On 9/1/23 at 9:19 AM, the surveyors met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The LNHA stated the Emergency food area did not meet the guidelines for storing the emergency food storage. A review of the three day disaster Menu reflected the following items which were not observed in the emergency food storage area: Juice Dry cereal Sliced bread Canned fruit Milk Coffee/tea Spam Beefaroni Cheese Three bean salad Cookies Dry cereal	E 015	for 6 months. to ensure that all the items listed on the 3-day disaster menu are maintained in that area and to ensure that the items are not expired. The results of this audit will be shared with the Quality Assurance team at the monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	

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E 015	Continued From page 3 Tuna fish Beet salad Pudding Peanut butter Jelly Canned vegetables Danish Green beans Applesauce Ham Mashed potatoes A review of the Emergency Preparedness Plan dated 4/24/23 revealed the facility should maintain at least a three-day supply of staple foods onsite ...the three-day supply of staple foods is to be maintained by the facility always. Provisions shall be stored in an area less likely to be affected by disaster. NJAC 8:39-31.6(n)	E 015		
F 000	INITIAL COMMENTS Complaint #: NJ 156271, NJ 163617, NJ 165481 Survey Date: 9/1/2023 Census: 72 Sample: 19+4 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		10/3/23

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F 550	Continued From page 4 §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this	F 550		

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F 550	Continued From page 5 subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to treat each resident with respect and dignity in a manner that promotes his/her quality of life. This deficient practice was identified for one (1) of 19 residents (Resident #27) reviewed for resident rights. This deficient practice was evidenced by the following: On 8/24/2023 at 10:32 AM, the surveyor observed Resident #27 seated in their wheelchair across from the nurse's station. Resident #27 asked the Acting Licensed Practical Nurse Unit Manager (LPN UM #1) if they can have their medication. LPN UM #1 responded that they would notify their nurse when they returned from break. Resident #27 stated to LPN UM #1 that there was a medication error and they did not receive their medication in the morning and wanted it now. LPN UM #1 sternly directed Resident #27 to go to their room. Resident #27 responded, EX Order 26 § 4b1 [redacted] At that time, LPN UM #1 again stated they would notify their nurse and transported the resident from the nursing station to the resident's room. On 8/24/2023 at 10:39 AM, the surveyor interviewed Resident #27 who stated that they wanted their medication at that time and that the interaction between them and LPN UM #1 was "always like that." On 8/24/2023 at 11:17 AM, the surveyor	F 550	1. Upon notification of the interaction between the LPN and Resident #27, the LPN was suspended pending the outcome of the investigation. The DON and the Social Service Director met with resident #27 to offer comfort and support. 2. All residents have the potential to be affected by this cited practice. 3. The LPN was educated by the Administrator and DON on resident sensitivity and resident rights and was reinstated to the facility on a 90-day probationary period. The LPN will meet weekly with the DON to review his behavior and to work on tactics to improve demeanor with residents. Facility Staff have been in-serviced by the Administrator and DON on Resident rights with special focus given to sensitivity and caring for residents especially for residents with accusatory behaviors toward staff. 4. The DON/Designee will monitor the LPN for 12 weeks for behavior and treatment of the residents. The Administrator/designee will observe staff to resident interactions on the nursing units weekly for 4 weeks and then monthly for 3 months to ensure that residents rights are not violated. The Administrator will interview 3 residents weekly for 4 weeks and then monthly for 3 months to ensure that they are treated properly. The results of these reviews will be	

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F 550	Continued From page 6 interviewed LPN UM #1 regarding their interaction with Resident #27. LPN UM #1 stated that Resident #27 asked for their medication too early and they didn't want Resident #27 to keep speaking about the medication in front of the surveyors, which prompted LPN UM #1 to transport Resident #27 to their room. LPN UM #1 stated Resident #27 had a tendency to ask for medication when it was too early and would threaten the staff. The surveyor reviewed the medical record for Resident #27. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included EX Order 26 § 4b1 [redacted] Resident #59 was then readmitted with a diagnoses which included EX Order 26 § 4b1 [redacted] A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 7/1/2023, reflected a brief interview for mental status (BIMS) score of [redacted] out of 15, which indicated a EX Order 26 § 4b1 . A review of the individualized comprehensive care plan (ICCP) included a focus area revised on 7/5/2023, that the resident had NJ Exec. Order 26:4.b.1 [redacted] towards the staff and was [redacted] towards the staff. Interventions included: intervene as necessary to protect the rights and safety of others. NJ Exec. Order 26:4.b.1 [redacted] The ICCP also identified another focus area revised on 4/9/23, that the resident was NJ Exec. Order 26:4.b.1 [redacted] decisions	F 550	shared with the Quality Assurance team at the monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this review.	

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F 550	Continued From page 7 as to how the resident spent leisure time, but due to NJ Exec. Order 26:4.b.1, and NJ Exec. Order 26:4.b.1, relied on staff support for meeting NJ Exec. Order 26:4.b.1 [redacted]. Interventions included: EX Order 26 § 4b1 [redacted] On 8/24/2023 at 11:50 AM, the surveyor interviewed the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) who confirmed that LPN UM #1's interaction with Resident #27 was not appropriate and they shouldn't have spoken to Resident #27 that way. When asked if Resident #27 had the right to be in the nurses area, the DON stated, "I think that [Resident #27] has a right to be there." The DON further stated that LPN UM #'1 had attended the facility's sensitivity training prior. During a follow up interview with the surveyor on 8/25/23 at 11:47 AM Resident #27 stated that they would have liked to stay at the nurses station, and did not feel that LPN UM #1's tone towards the resident was threatening but felt that LPN UM #1 "could talk to us [the residents] a little better". A review the facility's "Resident Rights" policy that was last reviewed April 2023, included...1) Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a) a dignified existence ...c)treated with respect, kindness, and dignity ...i) be supported by the facility in exercising his or her rights ...j) exercise his or her rights without interference, coercion, discrimination or reprisal from the facility ...	F 550		

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F 550	Continued From page 8 A review the facility's "LPN Charge Nurse Position Summary" policy with an effective date of October 2019, included...Implement and update care plans as appropriate ...direct the delivery of care using sound good judgement while applying the highest standards of care and within the nurse practice act. A review the facility's "Staff Sensitivity and Gentleness in Caring for Residents" training completed on 6/5/23, included...1) Be conscious of the need to be gentle in all care situations...3) Be aware of the resident's needs and apply those more gentle and cautious applications that show your skill and level of caring for residents. The DON acknowledged LPN UM #1 signature on 6/5/23.	F 550		
F 812 SS=E	NJAC 8:39-4.1(a)(12) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		10/3/23

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F 812	Continued From page 9 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to: a.) store, label, and date potentially hazardous foods to prevent food-borne illness, b.) air dry kitchen equipment in a manner to prevent microbial growth, c.) maintain kitchen equipment in a sanitary manner, d.) maintain proper kitchen sanitation practices. This deficient practice was evidenced by the following. On 08/22/23 at 9:35 AM, the surveyor, in the presence of the Food Service Director (FSD), toured the kitchen and observed the following: 1. In the reach-in refrigerator, sliced yellow American cheese wrapped in clear plastic that was not dated or labeled with a used-by date. The FSD stated that the staff should have labeled and dated when the cheese was sliced. Ten cupcakes in a store-bought plastic container were not labeled or dated. The FSD stated that the cupcakes were from the recreation department and should not have stored them there. The FSD discarded the cupcakes. 2. On the front of the stove, underneath the grill top, there was a buildup of brownish-dried substance. The FSD stated that this is from grease catcher where the grease collects, spills out, and runs down the front of the oven. When	F 812	1. The sliced yellow American Cheese and the 10 cupcakes that were not labeled and dated were discarded. The grease buildup on the oven was cleaned. The 4 hotel pans that were wet nesting were rewashed and dried properly. The opened packages of taco shells, the opened package of spaghetti, and the panko mix that were not labeled and dated were discarded. The Cook that entered the kitchen without a hairnet was educated by the Food Service Director on the requirement of wearing a hairnet upon entering the kitchen even for a moment. 2. All residents have the potential to be affected by this cited practice. 3. Dietary staff were in-serviced by the Food Service Director on the requirement to date and label all opened food items. Dietary staff has been in-serviced by the Food Service Director on the proper procedure to clean equipment and to follow the cleaning schedule. Dietary staff were in-serviced by the Food Service Director on the proper procedure to dry pans and on the requirement to not pile them directly on top of each other while they are wet to prevent wet nesting. Dietary staff were in-serviced by the Food Service Director on the requirement of	

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F 812	Continued From page 10 the FSD opened the double oven doors, the right and left side doors dropped simultaneously. The FSD stated that the hinges were bad, and the oven doors would not stay closed. The FSD stated he had temporarily placed latches on both sides of the oven to keep the oven doors closed until the oven was fixed. The FSD stated there is a cleaning schedule for the kitchen, including the stove. 3. On a metal rack, four hotel pans were wet nested, and the FDS removed the pans and placed them near the sink to be washed. 4. During a tour of the dry storage area, there was an opened box of taco shells with three opened packages wrapped in clear plastic that were not labeled or dated. The FSD removed and discarded them. There was a 20-pound box of spaghetti with an opened package of spaghetti wrapped in plastic that was not labeled or dated. A 5-gallon plastic container, identified as panko by the FSD, was not labeled or dated. 5. At 10:00 AM, the surveyor observed the cook enter the kitchen without a hair net. The cook stated that he should have had a hair net on because it is very unsanitary as hair could get into the food. The FSD was made aware at that time. On 8/23/23 at 9:19 AM, the surveyors met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) and were informed of the findings. The LNHA stated the cook should have put a hair net on before he walked into the kitchen, the stove is on the list to be replaced, and the staff will have a schedule to keep the stove clean.	F 812	wearing a hairnet upon entering the kitchen even for a moment. 4. The Administrator/designee will check the kitchen to ensure that all opened food is labeled and dated, cleaning procedure is being followed, there are no wet-nesting pans and that all staff are wearing hair/beard coverings while in the kitchen. This review will be done weekly for the first 4 weeks and then monthly for 3 months. The results of this audit will be shared with the Quality Assurance team at the monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	

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F 812	Continued From page 11 A review of the facility's policy, "Food Brought in from the Outside," dated 1/6/23, included a designated pantry space and refrigerators for residents' outside foods. A review of the facility's policy "Use of Hair Nets and Beard Nets" dated 3/10/23 included that hair nets and beard nets are necessary items required by the FDA and USDA in food handling settings ...When entering the kitchen, always wearing a hair net and beard net when handling food ...or any duty in the kitchen area is mandatory. They are an effective tool for preventing the spread of hair in food processing and food service. A review of the facility's policy "Food Labeling and Dating for Kitchen," dated 6/10/23, included all food ...should be labeled with the common name of the food, the date the food was made, and a use-by date. NJAC 8:39-17.2(g)	F 812		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the garbage container area free of garbage and debris. This deficient practice was evidenced by the following:	F 814	1. The debris around the dumpsters in the garbage area was cleaned up and disposed of properly. 2. All residents have the potential to be affected by this cited practice. 3. Housekeeping and Dietary staff were in-serviced by the Administrator to ensure that all trash is disposed of properly. The Maintenance and Housekeeping	10/3/23

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER CREEK NURSING AND REHABILITATION CENTER	524 WARDELL ROAD TINTON FALLS, NJ 07753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 814	Continued From page 12 On 8/22/23 at 9:35 AM, the surveyor, in the presence of the Food Service Director (FSD), toured the kitchen and the designated garbage area and observed the following: There were three dumpsters in the designated area for the facility's garbage. All three lids were opened and several garbage bags were filled with trash on the ground near the dumpsters. There was debris around all the dumpsters, and behind one of the dumpsters, there was furniture such as mattresses, frames for the beds, overbed tables, and dressers. The Food Service Director (FSD) stated that the housekeeping department was responsible for keeping the area clean. On 8/23/23 at 8:55 AM, the surveyor toured the garbage area in the presence of the FSD. The furniture was in one of the dumpsters, and there were piles of debris around the dumpsters. During an interview with the surveyor on 8/23/23 at 9:25 AM, the Director of Housekeeping, stated that there was construction at the facility that finished approximately two months ago, and the furniture was left behind the dumpsters. He said that he was unsure of where the furniture would go. He further stated that the garbage around the dumpsters was the responsibility of both maintenance and housekeeping to keep the area clean and that the area should not have been left like that. On 8/23/23 at 9:19 AM, the surveyors met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) and were informed of the findings. The LNHA stated that the garbage area did have furniture in the	F 814	Directors will ensure on their daily rounds that the trash area does not have any debris out of the dumpsters. 4. The Administrator/designee will check the garbage area to ensure that all trash is placed inside the dumpsters and that there is no debris around the dumpsters. This will be done weekly for 4 weeks and then monthly for 3 months. The results of this audit will be shared with the Quality Assurance team at the monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	

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F 814	Continued From page 13 area and that the area had "become a mess." Review of the facility policy titled Housekeeping-Outdoor Trash Area with a revised date of 2/2023, indicating that the housekeeping staff are responsible for regular cleaning and maintaining the outdoor trash. They will ensure that the area is free of litter and debris. The Maintenance team will ensure that the trash bins are in good condition and are adequately covered to prevent odors and pests. N.J.A.C. 8:39-19.3(c)	F 814		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records,	F 842		10/3/23

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F 842	Continued From page 14	F 842		

regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed

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F 842	Continued From page 15 professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records and other pertinent facility documentation it was determined that the facility failed to maintain medical records accurately and completely in accordance with acceptable standards and practice by not documenting pertinent clinical documentation on the resident's medical record for a resident who had a change in condition. This was identified for 1 of 18 residents (Resident #68) reviewed and was evidenced by the following. a.) According to Resident #68's medical record, the resident was admitted to the facility with the diagnoses which included but not limited to EX Order 26 § 4b1 [redacted] The significant change Minimum Data Set (MDS-a assessment that facilitates a resident's care) dated EX Order 26 § 4b1 indicated that the resident EX Order 26 § 4b1 [redacted] On EX Order 26 § 4b1, the surveyor was unable to interview Resident #68 because the resident was in the [redacted]. On 08/23/23 at 10:44 AM, the surveyor reviewed Resident #68's progress notes which revealed the following information: The nurses note date 08/19/2023 at 7:09 AM reflected the following documentation: Note Text:	F 842	1. Resident #68 was being monitored by nursing staff while the resident was waiting for the EX Order 26 § 4b1 [redacted] his was documented by the nursing staff as a late entry note on August 31, 2023. The Nurse that did not document timely has been educated by the Director of Nursing on the importance of documenting full set of NJ Exec. Order 26:4.b.1 [redacted] s in the residents medical record in a timely manner. 2. All residents that have had a change of condition have the potential to be affected by this practice. 3. Licensed nurses have been in-serviced by the Director of Nursing on the importance of documenting in the residents medical record their assessments of residents that have had a change of condition in a timely manner. This documentation should include a full set of NJ Exec. Order 26:4.b.1 [redacted] in addition to the nature of the change of condition. 4. The DON/designee will audit the medical records of 2 residents that had a change of condition requiring them to be transferred to the [redacted] to ensure that the nurses documented in the residents medical record a full set of NJ Exec. Order 26:4.b.1 [redacted] n addition to the nature of the change of condition.	

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F 842	Continued From page 16 'EX Order 26 § 4b1 X Order 26 § 4b1 [redacted] The nurses' notes dated 08/19/2023 at 8:31 AM reflected the following documentation: Note Text: 'EX Order 26 § 4b1 [redacted] " The nurses' notes dated on 8/19/2023 at 10:44 AM reflected the following documentation: Note Text: EX Order 26 § 4b1 [redacted] The nurses' notes dated on 8/19/2023 at 18:02 (6:02 PM) reflected the following documentation. Note Text: 'EX Order 26 § 4b1 [redacted] The surveyor reviewed the subsequent nurses' notes regarding Resident #68's change of condition on [redacted] which did not contain information regarding what the resident' [redacted] The surveyor reviewed the Weights and Vitals Summary dated for the month '[redacted]" and there was no documentation that the resident had NJ Exec. Order 26:4.b.1 [redacted] on EX Order 26 § 4b1 .	F 842	This will be done weekly for 4 weeks and then monthly for 3 months. The results of this audit will be shared with the Quality Assurance team at the Monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	

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F 842	Continued From page 17 On 08/23/23 at 11:11 AM, the surveyor interviewed the Licensed Practical Nurse (LPN#2). LPN #2 stated that if a resident had a change in condition that the nurse would perform an assessment. She stated that an assessment would include a full set of [redacted] She confirmed that all assessments performed would be documented in the resident's medical record. She continued to explain that the nurse would be required to fill out a Universal Transfer Form (UTF). She stated that a UTF was a communication form that was utilized between the facility and the [redacted] and would provide the [redacted] with information regarding the resident's medical condition, code status, resident information, vital signs and how to care for the resident. LPN #2 added the UTF was an important communication tool between the facility and the [redacted]. On 08/23/23 at 11:19 AM, the surveyor interviewed the acting LPN Unit Manager who stated that the nurse was responsible to assess the resident and to obtain a full set of vital signs if a resident had a change in condition. He added that the nurse would be responsible to complete a UTF. The LPN/UM confirmed that there was no VS documented in Resident #68's medical record when the resident [redacted] on [redacted]. He stated that this would have been important as the resident was admitted to the [redacted] He stated, "[redacted] " On 08/23/23 at 12:09 PM, the surveyor interviewed the DON in the presence of the	F 842		

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survey team. The DON explained that if a resident had a change in condition, the nurse would immediately physically assess the resident and obtain a full set of VS which would include EX Order 26 § 4b1 level of conscience, evaluate for pain etc. He stated that if VS were taken during the assessment, then it should be documented under the weights and VS section of the electronic medical record and in the nursing progress notes. The surveyor reviewed the progress notes that were written on 08/19/23 at 8:31 AM when Resident #68 had a change of condition and the DON confirmed that the documentation was not specific regarding what NJ Exec. Order 26:4.b.1 . The DON could not explain why the RN did not document that she had taken NJ Exec. Order 26:4.b.1 when the resident had a change in condition.

On 08/28/23 at 10:26 AM, the surveyor interviewed LPN who stated that that on 08/19/23, she arrived at the NJ Exec. Order late. She indicated that the 11:00 PM-07:00 AM shift Registered Nurse (RN) gave her report that Resident #68's EX Order 26 and that she was going to assess the resident before she left. She then explained that the RN then went back to assess the resident and she went back to performing her medication pass for other residents. She then added that the RN did not report to her that the resident NJ Exec. Order 26:4.b.1 . She stated that the RN only reported to her that the resident's NJ Exec. Order 26:4.b.1 and that the RN would notify the MD. LPN #1 then stated the RN told her that the MD ordered the resident to be sent to the EX Order 26 § 4b for NJ Exec. Order 26:4.b.1 .

LPN #1 and the surveyor reviewed the resident's

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progress notes. LPN #1 confirmed that the 11:00 PM-07:00 AM RN documented that Resident #68 had a EX Order 26 § 4b1 and confirmed that there was no further documentation or progress notes written until 10:44 AM when LPN #1 documented that the resident was NJ Exec. Order 26:4.b.1 to the EX Order 26 § 4b1

LPN #1 stated that she did check on Resident #68 between 08:31 AM and 10:44 AM she and the resident gave her a "EX Order 26 § 4b1". LPN #1 stated that she did not document the resident's condition in the resident's medical record while the resident was waiting for transport to the EX Order 26 § 4b1 The surveyor reviewed the resident medical records and there was no documentation regarding the resident's medical condition from EX Order 26 § 4b1 while the resident was waiting to be NJ Exec. Order 26:4.b.1 to the EX Order 26 § 4b1 for NJ Exec. Order 26:4.b.1 She stated that it would have been important to document on a resident who had a "change in condition", but that she was passing out medications to other residents and didn't have the time to perform the documentation until after the resident was already NJ Exec. Order 26:4.b.1 to the EX Order 26 § 4b1 The LPN admitted that she did not document in Resident #68's medical record any resident assessments subjective or objective that she performed for Resident #68 that was reported to have a EX Order 26 § 4b1

On 08/28/23 at 11:05 AM, the surveyor interviewed the RN who worked on 08/19/23 11:00 PM-07:00 AM shift on Unit 3 and sent the resident to the EX Order 26 § 4b1 to be evaluated for a EX Order 26 § 4b1 08/19/2023 at 8:31 AM. The RN described

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Resident #68 as being EX Order 26 § 4b1 [redacted]. The RN added that Resident #68 communicated NJ Exec. Order 26:4.b.1 [redacted]. She also indicated that the resident was NJ Exec. Order 26:4.b [redacted] and wants. She explained that Resident #68 had a EX Order 26 § 4b1 [redacted]. She stated that on 08/19/23 during the 11:00 PM-07:00 AM shift, the resident slept well and had EX Order 26 § 4b1. She stated that at the end of her shift and the beginning of the day shift the resident was noted to be NJ Exec. Order 26:4.b.1 the EX Order 26 § 4b1 and had appeared to be in NJ Exec. Order 26:4.b.1. She explained that when she asked the resident if he/she was in pain that the resident shook his/her head "EX O" indicating that he did not have NJ Exec. Orde. The RN then explained that she took the resident's NJ Exec. Order 26:4.b.1 in the middle of the shift and prior to noticing that the resident's "EX Order 26 [redacted]. She then added that she did not recall writing the resident's NJ Exec to include the resident's NJ Exec. Order 26:4.b.1 in the medical record, but recall did recall writing them on the UTF. The surveyor explained to the RN that upon the surveyor's review of the UTF, there were two sets of NJ Exec. Order 26:4.b.1 on the form and that one set of VS were typed and the other set of VS were handwritten. The RN confirmed that the typed NJ Exec were not the NJ Exec that she took and did not know how that set of NJ Exec got on the EX Order 2. She then confirmed that the handwritten EX Order 26 § 4b1 [redacted] were the NJ Exec that she had written on the EX Order 2. The RN could not explain to the surveyor why the resident's NJ Exec. Order 26:4.b.1 was not documented by her on the EX Order 2. The RN also confirmed that it would have been important to

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have documented the full set [NJ Exec. Order 26:4.b.1] to include [EX Order 26 § 4b1] The RN stated that it was the change of shift and that the other nurse that came on duty was also involved with the resident's change in condition and was surprised that the other oncoming nurse did not document her assessments of the resident in the medical record.

The surveyor reviewed the physician discharge summary dated [EX Order 26 § 4b1], which indicated that Resident #68 was noted to have a [EX Order 26 § 4b1] and was sent to the [EX Order 26 § 4b1] for [NJ Exec. Order 26:4.b.1] for [EX Order 26 § 4b1]. The surveyor was unable to locate any evidence in the medical record that indicated that the resident had [NJ Exec. Order 26:4.b.1] [EX Order 26 § 4b1] at the time that the resident was had a change of condition on [EX Order 26 § 4b1].

On 08/29/23 at 10:07 AM, the surveyor interviewed the primary care physician (PCP) who stated that the [NJ Exec. Order 26:4.b.1] that were documented on the resident's discharge summary dated [EX Order 26 § 4b1], were not accurate and not updated since his last assessment of the resident. He stated that the [NJ Exec. Order 26:4.b.1] that were documented on the discharge summary were not the [NJ Exec. Order 26:4.b.1] that were exhibited by Resident #68 at the time the resident had a change in condition and was sent to the [EX Order 26 § 4b1] for [NJ Exec. Order 26:4.b.1].

On 09/01/23 at 09:24 AM, the Administrator and DON provided progress notes for Resident #68 titled, "late entry for 8/19/13" which was dated 9/1/23 at 07:10 AM by the RN. Review of the progress note included documentation of the

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resident's NJ Exec. Order 26:4.b.1. The Administrator confirmed that the nurses should have documented their assessment and NJ Exec. prior to the late entry.

The surveyor reviewed the facility policy titled, "Change in Condition" with a revised date 04/2023 which indicated the clinical nurse will recognize and appropriately intervene in the event of a change in resident condition. The policy indicated that with a change in condition, the clinical nurse will gather all subjective and objective assessment information. The nurse was responsible to complete an assessment of the resident's condition to include vital signs, level of conscience and any other symptoms related to the resident's condition.

The surveyor reviewed the facility policy titled, "Nursing Documentation" with a revised date of 04/2023 which indicated that pertinent information should be documented in the individual's record in an accurate, timely and legible manner. It also indicated that the individual's record is a permanent legal document that provides a comprehensive account of information about the individuals health care status.

NJAC 8:39-35.2 (d)6, 16(e)

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to a. maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 6 of 14 day shifts reviewed. This deficient practice was evidenced by the following: 1.Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	1. The facility will schedule the nursing units as per state guidelines. This will be accomplished by offering extra shifts to current staff when needed and by using nursing agencies. 2. All residents have the potential to be affected by this cited practice. 3. The staffing coordinator was in serviced by the Administrator on the required staffing ratio for staff to resident as mandated by the state of New Jersey for each shift. 4. The Administrator/designee will review the daily staffing sheets to ensure that the minimum staff to resident ratio is met. This review will be done weekly for 4 weeks and then monthly for 3 months.	10/3/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061310	A. BUILDING: _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER CREEK NURSING AND REHABILITATION CEN	524 WARDELL ROAD TINTON FALLS, NJ 07753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift; One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties; and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report for the weeks of 2/5/23 and 2/12/23 revealed the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows: -08/07/23 had 8 CNAs for 73 residents on the day shift, required at least 9 CNAs. -08/08/23 had 8 CNAs for 73 residents on the day shift, required at least 9 CNAs. -08/10/23 had 8 CNAs for 73 residents on the day shift, required at least 9 CNAs. -08/12/23 had 8 CNAs for 73 residents on the day shift, required at least 9 CNAs. -08/13/23 had 8 CNAs for 72 residents on the day shift, required at least 9 CNAs. -08/15/23 had 8 CNAs for 72 residents on the day shift, required at least 9 CNAs. During an interview with a surveyor on 8/25/23 at	S 560	The results of this audit will be shared with the Quality Assurance team at the Monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061310	A. BUILDING: _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER CREEK NURSING AND REHABILITATION CEN	524 WARDELL ROAD TINTON FALLS, NJ 07753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 11:42 AM, the Staffing Coordinator stated she was familiar with minimum staffing ratio requirements. During an interview with the surveyor on 8/31/23 at 09:25 AM, the Administrator stated he was aware of the minimum staffing ratio requirements and reported that they continue to hire CNAs.	S 560		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315414	A. Building B. Wing	10/3/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER CREEK NURSING AND REHABILITATION CENTER	524 WARDELL ROAD TINTON FALLS, NJ 07753

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix E0015 Reg. # 483.73(b)(1) LSC	Correction Completed 10/03/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
9/1/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315414 Y1	A. Building B. Wing Y2	10/3/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER CREEK NURSING AND REHABILITATION CENTER	524 WARDELL ROAD TINTON FALLS, NJ 07753

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0812	Correction	ID Prefix F0814	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.60(i)(4)	Completed
LSC	10/03/2023	LSC	10/03/2023	LSC	10/03/2023
ID Prefix F0842	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/03/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/1/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061310 Y1	A. Building B. Wing Y2	10/3/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER CREEK NURSING AND REHABILITATION CENTER	524 WARDELL ROAD TINTON FALLS, NJ 07753

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 10/03/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/1/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. BUILDING **01** B. WING _____	**09/01/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER CREEK NURSING AND REHABILITATION CENTER	**524 WARDELL ROAD** **TINTON FALLS, NJ 07753**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/30/2023 and 08/31/2023 and Aster Creek was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Aster Creek is a two- story building that was built in 1990's It is composed of Type III construction. The facility is divided into 13 smoke zones.The generator does approximately 50% of the building. The fire pump gets water from the facility swimming pool thats not used for swimming.	K 000		
K 161 SS=E	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered	K 161		10/18/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/22/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. BUILDING **01** B. WING _____	**09/01/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER CREEK NURSING AND REHABILITATION CENTER	**524 WARDELL ROAD** **TINTON FALLS, NJ 07753**

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K 161	Continued From page 1 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/30/2023 and 08/31/2023, in the presence of the facility Management, it was determined that the facility's building, a two-story unprotected ordinary-type construction, did not comply with NFPA 101:2012 for an acceptable construction type. This deficient practice was evidenced by the following: The facility's building consisted of a two-story unprotected ordinary-type construction that was provided with a functional fire alarm and fire sprinkler systems that were tested in accordance	K 161	No residents were affected by this deficiency. All residents have the potential to be affected by this deficiency. A FSES evaluation will be done once the fire sprinkler conversion is completed. The sprinkler conversion project is currently waiting for approval from the DCA. Once the approval is received, the vendor is ready to complete the project. The Maintenance Director has been educated on the requirement to update the FSES annually. Results of the FSES will be reported to the quality Assurance team which will	

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ASTER CREEK NURSING AND REHABILITATION CENTER	**524 WARDELL ROAD** **TINTON FALLS, NJ 07753**

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K 161	Continued From page 2 with NFPA 72, 13, and 25. In an interview on 08/30/2023 (day one of survey) at approximately 8:52 AM, the surveyor informed the Administrator that the previously granted waiver for the building exceeding the height requirements for it's construction type and stated the facility's Fire Safety Evaluation System (FSES) failed due to the facility's issues with the fire sprinkler system.. During the interview, the Administrator told the surveyor that the facility had not connected the fire sprinkler system to the city water system yet. The surveyor informed the Administrator that the facility would need to submit a new FSES to the Department of Health. The facility was provided a letter for "instructions for past WAIVERED citations.. The Administrator was provided a contact email if any questions were to occur and informed a new FSES (Fire Safety Evaluation System) is required to be conducted for every recertification survey in which the deficiency is cited.	K 161	make further recommendations based on the results of the FSES.	
K 271 SS=D	NJAC 8:39-31.2(e) Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface.	K 271		9/22/23

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ASTER CREEK NURSING AND REHABILITATION CENTER	**524 WARDELL ROAD** **TINTON FALLS, NJ 07753**

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K 271	Continued From page 3 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 08/30/2023 and 08/31/2023 in the presence of facility management, it was determined that the facility failed to provide a stable/suitable and free of obstructions walking surface for evacuation at 1 of 6 designated exit discharges that would serve Residents, Visitors and Staff in the event of an emergency evacuation. This deficient practice was evidenced by the following: On 08/30/2023 (day one of survey) during the survey entrance at approximately 8:52 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story building with six (6) designated exit discharge (illuminated exit signs) doors in the facility. Starting at approximately 9:16 AM on 08/30/2023 and continued on 08/31/2023 in the presence of the facility MD a tour of the facility was performed. Along the two day tour the surveyor observed the following: 1. On 08/31/2023 at approximately 10:51 AM, an inspection outside a designated exit discharge door leading out of the Physical Therapy area	K 271	The exit discharge path leading out of the Physical Therapy area was cleaned up to ensure proper egress and a clear passageway to a public way in case of an emergency. All residents have the potential to be affected by this cited deficiency. All exit discharge ways from the facility have been inspected to ensure that there are no obstructions and that there is a clear passage leading to a public way. The Administrator educated the Maintenance Director on the requirement of ensuring that all emergency exits have proper egress and a clear passageway to a public way. The Maintenance Director will Check all emergency exits weekly for 4 weeks and then monthly for 3 months to ensure that there are no obstructions and that there is clear passage leading to a public way. The results of this audit will be shared with the Quality Assurance team at the Monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	

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K 271	Continued From page 4 was performed. The surveyor observed the exit discharge path had green moss (damp and slippery when stepped on), stones, pieces of broken masonry and a large bush branches blocking the egress path that would lead you to a public way. A review of an emergency evaluation diagram posted inside the building identify the exit discharge as the primary and or secondary exit discharge to reach a public-way. The MD confirmed the findings at the times of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 08/31/2023 at approximately 12:45 PM. Life Safety Code 101 - 18.2.7 NJAC 8:39-31.2(e)	K 271		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 08/30/2023 and	K 293	An additional illuminated exit sign has been placed in the corridor so that it will	10/13/23

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K 293	Continued From page 5 08/31/2023 in the presence of facility management, it was determined that the facility failed to provide two (2) illuminated exit signs to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 Reference: New Jersey Uniform Construction Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to	K 293	be visible from resident rooms #3[redacted] and #3[redacted] An illuminated exit sign has been placed above the exit discharge door for the kitchen and laundry. All residents have the potential to be affected by this cited practice. The Administrator educated the Maintenance Director to ensure that illuminated exit signs are visible in all locations of the hallways and that are exit doors have an illuminated exit sign. A review was done in the facility to ensure that an illuminated exit sign identifying the exit access path is visible in all locations of the hallways. All exit doors have been checked to ensure that they have an illuminated exit sign. The Maintenance Director will Check all illuminated exit signs monthly to ensure that they are in working order. The results of this audit will be shared with the Quality Assurance team at the Monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 293	Continued From page 6 exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign." On 08/30/2023 (day one of survey) during the survey entrance at approximately 8:52 AM, a request was made to the Administrator (Admin.) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. The surveyor also asked how many resident sleeping rooms were in the facility. The Admin. told the surveyor that there are 39 Resident sleeping rooms. A review of the facility provided lay-out identified the facility was a two-story building. There were 39 resident sleeping rooms and common areas on the 1st. and 2nd. floors. Starting at approximately 9:16 AM on 08/30/2023 and continued on 08/31/2023 in the presence of the facility MD a tour of the facility was performed. During the two (2) day building tour the of the facility the surveyor observed two (2) locations that failed to have illuminated exit signs to clearly identify the exit access route to reach an exit in the following locations, On 08/30/2023: 1) At approximately 10:35 AM, the surveyor	K 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. BUILDING **01** B. WING _____	**09/01/2023**

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K 293	Continued From page 7 observed on the second floor Unit #3, and while standing in the corridor near resident rooms #[redacted] and #3[redacted] looking down the ramp corridor towards resident rooms #3[redacted] and #[redacted] an illuminated exit sign to identify the exit access route was not visible. On 08/31/2023: 2) At approximately 10:24 AM, the surveyor observed no evidence of an illuminated exit sign inside the stairwell and above the exit discharge door for the Kitchen and Laundry room. The MD confirmed the findings at the times of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 08/31/2023 at approximately 12:45 PM. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c) NFPA Life Safety Code 101 2012 -7.7	K 293		
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control	K 341		9/22/23

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ASTER CREEK NURSING AND REHABILITATION CENTER	**524 WARDELL ROAD** **TINTON FALLS, NJ 07753**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 341	Continued From page 8 unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility provided documentation on 08/30/2023 and 08/31/2023, in the presence of the facility management, it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 1 of 1 outside second floor Residents smoking patio area in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9 The deficient practice was evidenced by the following: On 08/30/2023 (day one of survey) during the survey entrance at approximately 8:52 AM, a request was made to the Administrator (Admin) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms in the facility. The surveyor also asked how many resident sleeping rooms were in the facility. The Admin. told the surveyor that there were 39 Resident sleeping rooms. A review of the facility provided lay-out identified the facility was a two-story building. There were	K 341	An audio and visual fire alarm has been installed in the outside resident smoking patio. All residents have the potential to be affected by this cited deficiency. The Administrator educated the Maintenance Director on the requirement to ensure that there is an audio and visual fire alarm in all required areas of the facility. A review was done in the facility to determine if there are any other areas which will require an audio and visual fire alarm to be installed. No other areas were identified. This review will be shared with the Quality Assurance team at the monthly and quarterly meetings for the next 2 quarters.	

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K 341	Continued From page 9 39 resident sleeping rooms and common areas on the 1st. and 2nd. floors. Starting at approximately 9:16 AM on 08/30/2023 and continued on 08/31/2023 in the presence of the facility MD a tour of the facility was performed. On 08/30/2023 (day one of survey) at approximately 10:00 AM, an inspection of the second floor outside resident smoking patio area was performed. The surveyor observed that the facility failed the have an audio and visual alarm to notify Resident, Staff and Visitors of an activation of the buildings fire alarm system. At that time the surveyor asked the Admin, "Do you have an audio and visual alarm tied into the buildings fire alarm system?". The Admin looked around and told the surveyor, "no." The MS confirmed the findings at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 08/31/2023 at approximately 12:45 PM. NJAC 8:39-31.2(a) NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9	K 341		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING	K 351		10/13/23

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K 351	Continued From page 10 Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 08/30/2023 and 08/31/2023, in the presence of facility management it was determined that the facility failed to provide fire sprinkler coverage to all areas of the facility as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition The deficient practice was evidenced by the following: On 08/30/2023 (day one of survey) during the survey entrance at approximately 8:52 AM, a request was made to the Administrator (Admin.) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various	K 351	A sprinkler head has been placed in the elevator mechanical room. All residents have the potential to be affected by this cited deficiency. The Administrator educated the Maintenance Director on the requirement of ensuring that that all required areas have a sprinkler head. A review was done in the facility to determine if there are any other areas that do not have a sprinkler head. No other areas were identified. This review will be shared with the Quality Assurance team at the monthly and quarterly meetings for the next 2 quarters.	

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K 351	Continued From page 11 rooms and smoke compartments in the facility. The surveyor also asked how many elevators are in the building. A review of the facility provided lay-out identified the facility is two (2) story building with one elevator. Starting at approximately 9:16 AM on 08/30/2023 and continued on 08/31/2023 in the presence of the facility MD, a tour of the facility was performed. Along the tour, the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: On 08/31/2023: 1) At approximately 8:30 AM, the surveyor observed the corridor door leading into the elevator mechanical room was propped in the open position. At this time the surveyor observed an elevator mechanic working inside the room. The surveyor asked the elevator mechanic, are there any fire sprinklers in the room and elevator hoist-way. The elevator mechanic told the surveyor he didn't know. He is only programming the emergency communications telephone. The surveyor observed no evidence of fire sprinkler coverage inside the 6'-4" deep by 7'- 1" wide elevator mechanical room. Later at approximately 11:30 AM, in the presence of the MD a second inspection inside the elevator mechanical room was conducted. At that time, the surveyor asked the MD, "Do you see any fire sprinklers in this room?" The MD looked up and around the room and said, "no."	K 351		

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K 351	Continued From page 12 The facility failed to provide fire sprinkler coverage to all areas in the facility. The MD confirmed the findings at the times of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 08/31/2023 at approximately 12:45 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 353		10/18/23

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K 353	Continued From page 13 REPEAT DEFICIENCY Based on Interview and review of facility provided documentation on 08/30/2023 and 08/31/2023, it was determined that the facility failed to follow their Plan of Correction (POC) for the re-certification survey of 06/14/2021. The evidence includes the following, On 08/30/2023 (day one of survey) at 8:52 AM, a request was made to the facility's Administrator (Admin) if the facility had any waivers. The Admin told the surveyor, "yes, we have a Time Limited Waiver for our fire sprinkler system." A request was made to the Admin to provide copies of the POC and Time Limited Waiver. On 08/31/2023 at approximately 8:30 AM, the Admin provided the POC, Time Limited Waiver and a proposal to complete the work. A review of the facility provided POC reads in part, "The facility is scheduled to convert the fire sprinkler system from the water storage tank (pool) to city water. A deposit has been given for this project and it will be completed once all required approvals are obtained. The facility has submitted a Time Limited Waiver to have this project completed." A review of the facility provided Time Limited Waiver (date submitted 07/29/2021)reads in part, "The facility has initiated the process to convert the fire sprinkler system to city water." Estimated Completion date: (cannot be more than 5 years from the survey exit date):	K 353	No residents were affected by this deficiency. All residents have the potential to be affected by this deficiency. The facility signed a proposal for the sprinkler conversion along with a deposit given on 8/18/2021. A Time Limited waiver was submitted for this with an anticipated completion date of December 15, 2021. This project has been held up at the DCA and has not yet been approved. DCA approval for this project is anticipated shortly. Once approval is received, the vendor will complete the sprinkler conversion. Until this project is completed, the following alternative measures are being done. The Maintenance Director/designee will check the water level weekly, the pool is being treated weekly with chemicals to keep the water clean, and the filter is being checked weekly for cleanliness. The progress of this project will be shared with the Quality Assurance team at the monthly and quarterly meetings which will make further recommendations based on the progress of this project.	

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K 353	Continued From page 14 December 15, 2021. The facility did not meet the Time Limited Completion date of December 15, 2021. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 08/31/2023 at approximately 12:45 PM. NFPA 13, 25. NJAC 8:39-31.2 (e).	K 353		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 05/18/2023 and 05/19/2023 in the presence of facility management, it was determined that the facility failed to perform hydrostatic testing for 13 of 21 fire extinguishers, as required by National Fire Protection Association NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3. and N.J.A.C. 5:70. This deficient practice was evidenced by the following: Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads,	K 355	The fire extinguishers that were found to be out of date with hydrostatic testing were replaced with fire extinguishers that were within date. All residents have the potential to be affected by this cited practice. The Administrator educated the Maintenance Director on the different types of fire extinguisher testing requirements and when they need to be done. A review was done on all the fire extinguishers in the facility to ensure that they had a hydrostatic test within the past 6 years. Any fire extinguisher that has been found to be out of compliance has	9/22/23

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K 355	Continued From page 15 - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4- 3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 4- 4.3 Six Year Maintenance, Every 6 years, stored-pressure fire extinguishers shall require a hydrostatic test shall be emptied and subjected to the applicable maintenance procedures. The removal of agent from halon agent fire extinguishers shall only be done using a listed halon recovery systems. When the applicable maintenance procedures are performed during periodic recharging or hydrostatic testing, the 6-year requirement shall be from that date. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. On 08/30/2023 (day one of survey) during the survey entrance at approximately 8:52 AM, a request was made to the Administrator (Admin.) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified	K 355	been replaced. A list has been created listing all the fire extinguishers in the facility with the date that the next hydrostatic testing is due. The Maintenance Director will use this list as a guide to ensure that hydrostatic testing is performed when required. This list will be shared with the Quality Assurance team at the Monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of the list.	

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K 355	Continued From page 16 the facility was a two-story building. There were 39 resident sleeping rooms and common areas on the 1st and 2nd floors. At approximately 9:16 AM on 08/30/2023 which continued on 08/31/2023 in the presence of the facility MD, a tour of the facility was performed. During the two (2) day building tour the of the facility, the surveyor observed and inspected twenty one (2) portable fire extinguishers in various locations that were last annually inspected September 2022 with the following results: On 08/30/2023: 1) At approximately 9:55 AM, the surveyor observed in the corridor Unit 2 across from room #[redacted], One "ABC" Type fire extinguisher near the Medical supplies room last Hydrostatic tested June 2006. 2) At approximately 10:03 AM, the surveyor observed in the Resident Dining room, One "ABC" Type fire extinguisher last Hydrostatic tested July 2012. 3) At approximately 10:10 AM, the surveyor observed near the TV room, One "ABC" Type fire extinguisher (#21) last Hydrostatic tested June 2006. 4) At approximately 10:15 AM, the surveyor observed on Unit #3 near Resident room #317, One "ABC" Type fire extinguisher had a Hydrostatic collar with the years 2005, 2006, 2007 and 2008. There was no evidence of a year	K 355		

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K 355	Continued From page 17 being punched. 5) At approximately 10:35 AM, the surveyor observed at the Unit #3 Nursing station, One "ABC" Type fire extinguisher last Hydrostatic tested 2015. 6) At approximately 10:43 AM, the surveyor observed on Unit #3 near the elevator, One "ABC" Type fire extinguisher last Hydrostatic tested July 2012. 7) At approximately 11:00 AM, the surveyor observed in the corridor near the Janitors closet, One "ABC" Type fire extinguisher last Hydrostatic tested June 2006. 8) At approximately 11:20 AM, the surveyor observed at the 400's Nursing station, One "ABC" Type fire extinguisher last Hydrostatic tested June 2012. On 08/31/2023: 9) At approximately 10:30 AM, the surveyor observed in the Laundry room, One "ABC" Type fire extinguisher last Hydrostatic tested July 2012. 10) At approximately 10:34 AM, the surveyor observed in the corridor going into Unit #1, One "ABC" Type fire extinguisher last Hydrostatic tested July 2013. 11) At approximately 10:36 AM, the surveyor observed in the corridor of Unit #1 near the oxygen storage room, One "ABC" Type fire extinguisher last Hydrostatic tested July 2012. 12) At approximately 10:41 AM, the surveyor observed at Unit #1 Nursing station, One "ABC"	K 355		

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K 355	Continued From page 18 Type fire extinguisher last Hydrostatic tested June 2006. 13) At approximately 10:50 AM, the surveyor observed in the corridor Unit #1 next to the exit discharge door, One "ABC" Type fire extinguisher last Hydrostatic tested July 2012. The MD confirmed the findings at the times of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 08/31/2023 at approximately 12:45 PM. NFPA -10. NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed	K 363		9/22/23

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ASTER CREEK NURSING AND REHABILITATION CENTER	**524 WARDELL ROAD** **TINTON FALLS, NJ 07753**

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K 363	Continued From page 19 when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 08/30/2023 and 08/31/2023, in the presence of facility management it was determined that the facility failed to ensure that 5 of 26 corridor doors inspected and tested, were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice was evidenced by the following: On 08/30/2023 (day one of survey) during the survey entrance at approximately 8:52 AM, a request was made to the Administrator (Admin.) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various	K 363	The corridor door in Resident room [NJ Exec. 0] has been adjusted to eliminate the 5/8-inch gap along the top edge The corridor door on Unit 3 soiled utility room has been adjusted to eliminate the 1/2-inch along the top of the door. Door bottoms have been placed on the corridor doors of Resident rooms #[NJ Exec. 0] and #[NJ Exec. 0] to ensure that the gap is less than 1 inch. All residents have the potential to be affected by this cited practice. The Administrator educated the Maintenance Director on the acceptable limits of a gap for corridor doors. A review was done of the corridor doors of the facility to ensure that there are no gaps that are out of compliance. Any door	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. BUILDING **01** B. WING _____	**09/01/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER CREEK NURSING AND REHABILITATION CENTER	**524 WARDELL ROAD** **TINTON FALLS, NJ 07753**

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K 363	Continued From page 20 rooms and smoke compartments in the facility. The surveyor also asked how many Resident sleeping rooms were in the facility. The Admin. told the surveyor that there were 39 resident sleeping rooms. A review of the facility provided lay-out identified that the facility was a two-story building. There were39 resident sleeping rooms and common areas on the 1st. and 2nd. floors. At approximately 9:16 AM on 08/30/2023 and continued on 08/31/2023 in the presence of the facility MD a tour of the facility was performed. During the tour the surveyor performed closure tests of the twenty six (26) doors in the corridors with the following results, On 08/30/2023: 1) At approximately 10:21 AM, on Unit 3 Resident room #317, during a closure test of the corridor door the surveyor observed an approximately 5/8 gap along the top edge. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 2) At approximately 10:24 AM, on Unit 3 Soiled Linen room, during a closure test of the corridor door the surveyor observed an approximately 1/2 gap along the top door. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 3) At approximately 11:02 AM, on Unit 4 Resident room #[redacted], during a closure test of the corridor door the surveyor measured and recorded a 2 inch gap along the bottom edge of	K 363	that has been found to be out of compliance has been corrected. The Maintenance Director will check corridor doors monthly for 6 months to ensure that all gaps are within acceptable limits. The results of this audit will be shared with the Quality Assurance team at the Monthly and quarterly meetings for the 2 quarters which will make further recommendations based on the results of this audit.	

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	315414	A. BUILDING **01** B. WING _____	**09/01/2023**

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ASTER CREEK NURSING AND REHABILITATION CENTER	**524 WARDELL ROAD** **TINTON FALLS, NJ 07753**

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K 363	Continued From page 21 the corridor door. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 4) At approximately 11:23 AM, on Unit 4 Resident room [NJ Exec. Ord.], during a closure test of the corridor door the surveyor measured and record a 1-1/2 gap along the bottom edge of the corridor door. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 5) At approximately 11:25 AM, on Unit 4 Resident room [NJ Exec. Ord.], during a closure test of the corridor door the surveyor measured and recorded a 1-1/2 inch gap along the bottom edge of the corridor door. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. A review of facility emergency evacuation diagrams posted in the corridors identified that you would need to pass these 5 corridor doors as the primary and/ or secondary exit access route to reach an exit. The MD confirmed the findings at the times of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 08/31/2023 at approximately 12:45 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 531 SS=E	Elevators CFR(s): NFPA 101	K 531		9/22/23

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ASTER CREEK NURSING AND REHABILITATION CENTER	**524 WARDELL ROAD** **TINTON FALLS, NJ 07753**

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K 531	Continued From page 22 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 08/30/2023 and 08/31/2023, in the presence of facility management it was determined that the facility failed to maintain elevator emergency communications in proper working condition for 1 of 1 elevators tested, in accordance with ASME/ANSI A17.3. This deficient practice was evidenced by the following: On 08/30/2023 (day one of survey) during the survey entrance at approximately 8:52 AM, a request was made to the Administrator (Admin.) and Maintenance Director (MD) how many elevators were in the building. The Admin. told the	K 531	The elevator phone has been repaired and is now working. All Residents have the potential to be affected by this cited practice. The Administrator educated the Maintenance Director on the requirement of ensuring that the elevator phone is operational. The Elevator Service company will test the phone on their scheduled monthly maintenance checks to ensure that it is operational. The Maintenance Director will check the phone monthly to ensure that it is operational. This will be reported to the Quality	

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K 531	Continued From page 23 surveyor that there was one (1) elevator. Starting at approximately 9:16 AM on 08/30/2023 (day one of survey) in the presence of the facility MD a tour of the facility was performed. During the start of the tour at 9:17 AM, a test of elevator #1 emergency communication telephone was performed. When the surveyor pressed the button for the emergency communication phone, it did not function properly; the emergency communication phone did not dial. T he MD confirmed the finding at the time of the observation. At approximately 9:25 AM, the Admin. joined the building tour. At that time the surveyor informed the Admin. that the elevator emergency phone did not function properly. The Admin. wanted to do a second test of the emergency communication telephone. The Admin. pressed the emergency phone button inside the elevator. The emergency phone did not function. On 08/31/2023 (day two of survey) at approximately 8:30 AM, the surveyor observed an elevator mechanic in the elevator mechanical room. The surveyor asked the mechanic if they were working on the emergency communication phone. The elevator mechanic told the surveyor that he was programming the emergency telephone. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 08/31/2023 at approximately 12:45 PM. NJAC 8:39-31.2(e)	K 531	Assurance team at the monthly and quarterly meetings for the next 2 quarters, which will make further recommendations based on the results of this audit.	

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K 531	Continued From page 24 ASME/ANSI A17.3	K 531		
K 916 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 08/30/2023 in the presence of facility management, it was determined that the facility failed to provide a working remote annunciator panel for one (1) of one (1) emergency generator's electrical system to alert staff of the system's condition in accordance with National Fire Protection Association (NFPA) 99. This deficient practice was evidenced by the following: On 08/30/2023(day one of survey) during the survey entrance at approximately 8:52 AM, a request was made to the Administrator (Admin) and Maintenance Director (MD), "Does the facility have an emergency generator and where is the location of the remote annunciator panel for the generator?" The MD told the surveyor they had one (1) Diesel emergency generator and that the generator annunciator panel was located at the	K 916	The Generator annunciator has been replaced and is now working. All residents have the potential to be affected by this cited practice. The Administrator educated the Maintenance Director on the requirement of having a generator annunciator inside the facility. The Maintenance Director will test the generator annunciator monthly to ensure that it is working properly. The results of this testing will be shared with the Quality Assurance team at the Monthly and quarterly meetings for the next 2 quarters which will make further recommendations based on the results of this audit.	9/22/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 916	Continued From page 25 400's Nursing Station. On 08/30/2023 (day two of survey) during a tour of the building with the facility Admin and MD at approximately 11:21 AM, an inspection at the 400's Nursing station was performed. The surveyor observed that the emergency generators annunciator panel had an indicating light illuminated. The panel indicated that the emergency generator was "Running". At that time, the surveyor asked the MD, "Is your generator running now?" The MD told the surveyor, "no it's not running." A request was made to the Admin to press the test button on the annunciator panel to light up all of the indicating light. When the Admin pressed the test button, no indicator lights illuminated. When the surveyor pressed the test button to activate all of the indicator lights, no lights illuminated. The MD confirmed the findings at the times of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 08/31/2023 at approximately 12:45 PM. Reference: NFPA 99 - 6.4.1.1.17 Alarm Annunciator. A remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see 700.12 of NFPA 70, National Electrical Code). The annunciator shall be hard-wired to indicate alarm conditions of the	K 916		

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K 916	Continued From page 26 emergency or auxiliary power source as follows: (1) individual visual signals shall indicate the following: (a) When the emergency or auxiliary power source is operating to supply power to load. (b) When the battery charger is malfunctioning. (2) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall include the following: (a) Low lubricating oil pressure (b) Low water temperature (below that requirement in 6.4.1.1.11) (c) Excessive water temperature (d) Low fuel when the main fuel storage tank contains less that a 4-hour operating supply (e) Over crank (failed to start) (f) Over speed NJAC 8:39-31.2(e) NFPA 99, 110	K 916		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315414 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	11/10/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER CREEK NURSING AND REHABILITATION CENTER	524 WARDELL ROAD TINTON FALLS, NJ 07753

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0271	09/22/2023	LSC K0293	10/13/2023	LSC K0341	09/22/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	10/13/2023	LSC K0355	09/22/2023	LSC K0363	09/22/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0531	09/22/2023	LSC K0916	09/22/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/1/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315414	A. Building 01 - MAIN BUILDING 01 B. Wing	2/27/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER CREEK NURSING AND REHABILITATION CENTER	524 WARDELL ROAD TINTON FALLS, NJ 07753

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0161	Correction Completed 01/02/2024	ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 01/02/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 9/1/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?		☐ YES ☐ NO	